Application for Disability Income Insurance

Guaranteed Standard Issue

Founded in 1867... A Stock Company

This packet includes an application for Guaranteed Standard Issue disability income insurance and the Notice of Insurance Information Practices. Forward the entire application to the Home Office intact.

Please be sure:

(1) The Notice of Insurance Information Practices is delivered to the proposed insured before completion of the application.

(2) All sections of the application are complete.

(3) The proposed insured reads and signs the Authorization to Obtain and Disclose Information.

(4) The owner provides his/her Tax Identification Number (social security number) at the bottom of the Authorization page and certifies with a signature that it is correct. The owner is the same as the proposed insured in most instances.

(5) The proposed insured, owner (if other than the insured), and producer read and sign the Agreement page.

(6) The Conditional Receipt is given to the premium payor whenever full initial premium is collected from the proposed insured. Premium payment must be made by personal check only. No cash, money orders, traveler's checks, or bank checks are permitted.

The Union Central Life Insurance Company, P.O. Box 40888, Cincinnati, OH 45240-0888

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A UNIFI Company

Notice of Insurance Information Practices

To issue an insurance policy we need to obtain information about you. Some of that information will come from you and some will come from other sources. We may obtain information relating to the proposed insured's mental and physical health, habits, finances, occupation, and other insurance coverage.

This information may be obtained from physicians, medical professionals, hospitals, clinics or other medical care institutions, or from the Medical Information Bureau, Inc., public records, consumer reporting agencies, financial sources, other insurance companies, and agents. We may obtain information through exchanges or correspondence, by telephone or by personal contact.

Information regarding your insurability or claims will be treated as confidential. The Union Central Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. ("the Bureau"), a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112; telephone number (617) 426-3660. The Union Central Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

In the event of an adverse underwriting decision, upon written request, we will provide you with the specific reason in writing for the adverse underwriting decision.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. A description of the circumstances under which information about you might be disclosed without your authorization will be sent to you upon request.

You have a right of access to personal information we maintain in our files and to request correction, amendment, or deletion of any information you believe to be incorrect. You may request a description of established procedures which will allow access to and correction of such personal information.

If you wish to have a more detailed explanation of our information practices, including your rights of access to and correction of personal information, please contact: Underwriting Department, The Union Central Life Insurance Company, P.O. Box 40888, Cincinnati, Ohio 45240-0888.

DETACH AND DELIVER TO PROPOSED INSURED BEFORE COMPLETION OF THE APPLICATION.

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Application for Disability Income Insurance Guaranteed Standard Issue (GSI)

A. Personal Information (Proposed Insured)

Full Name: ______ ☐ Male ☐ Female
Home Address: ______ City: ______ State: ______ Zip: ______
Social Security Number: ______ Birth State: ______ Date of Birth: ______ Age: ______
Are you a U.S. citizen? ☐ Yes ☐ No If "No," what country? ______ Type of Visa: ☐ Perm ☐ Temp
Current Earned Annual Income (Salary, Fees, Commission & Bonus): ______
Have you used any tobacco products in the past 12 months? ☐ Yes ☐ No

B. Employment Information

Primary Employer: UT System Medical Foundation
Address: 6431 Fannin Street - Suite JJL-310 City: Houston State: TX Zip: 77030
Date of Hire: ______ Occupation: ______ Occupation Class: ☐ 5AP ☐ 5A ☐ 4A ☐ 3AP
Are you actively at work on a full-time basis (30 hours or more per week)? ☐ Yes ☐ No

C. Premium Information

Premium Mode: ☑ Monthly List Bill ☐ Monthly Electronic Fund Transfer (complete EFT form) ☐ Other: ______
Percentage of the premium paid by: the employer ______ %; the employee ______ %
If all or part of the premium is paid by your employer, will it be included in your taxable income? ☐ Yes ☐ No

D. Coverage Applied For

Coverage	Monthly Benefit	Waiting Period (days)	Maximum Benefit Period	Other Benefits		Own Occupation Definition	
Base	$ 3000			☑ Residual	☐ Residual (24 months)	☐ Benefit Duration	☐ Benefit Duration/NW
CAT	$			☐ Partial	☐ Other ______	☐ 60 Months	☐ 60 Months/NW
SIS	$			☑ COLA		☐ 24 Months	

Will the owner of the policy be someone other than the proposed insured? ☐ Yes ☑ No
If Yes, print full name and relationship to the proposed insured:

E. Other Insurance: If none, check here ☐

List all disability income in force, currently applied for or which you will become eligible for in the next 12 months. Include individual, group, or any coverage offered through your employer or an association. Provide policy number and issue date if replacing coverage.

Company Name	Type of Coverage	Monthly Benefit (Base+SIS)	Benefit Period	CAT Monthly Benefit	Employer Paid	Will Coverage Be Replaced?	(If replacing) Policy Number	(If replacing) Issue Date
TMAIT	Group	66%	SSNRA					
		$		$	☐ Yes ☐ No	☐ Yes ☐ No		
		$		$	☐ Yes ☐ No	☐ Yes ☐ No		

Other than listed above, are you covered by or eligible for a salary continuation plan? ☐ Yes ☐ No
If Yes, provide monthly amount: $ ______ or percent of income paid: ______ % and Benefit Period: ______ months.

F. Health Information

1. During the past 6 months, have you missed work, or worked less than a full-time schedule, due to illness or injury? ☐ Yes ☐ No
2. Have you ever had a total loss of: speech; or hearing in both ears; or sight in both eyes; or use of both hands, both feet, or one hand and one foot? ☐ Yes ☐ No

If the answer to any question 1 or 2 is "Yes," please provide details in the space below.

______

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Application for Disability Income Insurance

Agreement

The proposed insured represents that the statements in this application are true and complete to the best of his/her knowledge and belief. It is agreed that:

(a) the only statements to be considered as the basis of the policy are those contained in this application or in any amendment to this application;

(b) any prepayment made by the proposed insured, on the date the application is signed and dated, will be subject to the provisions of the CONDITIONAL RECEIPT;

(c) **when the proposed insured makes no prepayment with this application, or if the employer named in this application ("the Employer") is paying the entire cost of coverage (whether or not prepayment is made)**, if this application is approved and the proposed insured's health and the facts and other conditions affecting his/her insurability remain as described in this application, insurance will take effect on the policy issue date agreed upon by The Union Central Life Insurance Company ("the Company") and the Employer, subject to receipt by the Company of the initial premium payment;

(d) premium will not be considered paid until received by the Company, regardless of whether coverage is funded by the Employer, employee, or some combination thereof. If the Employer is deducting the proposed insured's portion of the premium from his/her paycheck, it is understood that the Employer is acting on his/her behalf when remitting premiums to the Company;

(e) if the Employer is paying the entire cost of the policy resulting from this application and the Company determines that the insured qualifies for an annual increase in the policy's maximum monthly benefit, he/she authorizes such an increase provided the Employer agrees to pay the cost of the increase. An increase applies only to a period of disability that starts on or after the effective date of the increase;

(f) the coverage applied for with this application, or any future increase in coverage, will become void from the date that coverage took effect, if the proposed insured is not actively at work on a full-time basis (30 hours or more per week) performing all of the duties of his/her occupation for the Employer, as of the effective date of that coverage. All premiums will be returned and no benefits will be payable for that coverage;

(g) coverage is issued based on the replacement information provided in this application. If any policies are to be replaced and such insurance is not canceled on a timely basis, any policy issued as a result of this application will be void from the beginning, all premiums will be returned, and no benefits will be payable;

(h) no one except the President, a Vice President, the Secretary, or an Assistant Secretary may make, alter or discharge contracts or waive any of the Company's rights or requirements; and

(i) the application was signed and dated in the state indicated below.

Fraud Notice: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Dated at: ______ City ______ State ______ Month ______ Day ______ Year

Print or Type Proposed Insured Name.	X Signature of Proposed Insured.
Print or Type Owner if not Proposed Insured.	X Signature of Owner if not Proposed Insured.
Richard Cunningham Print or Type Producer Name.	X Signature of Licensed Producer.
AG00073317-02 Producer Number & Situation Code.	Producer State License Number.
Dallas DI Center Agency Name.	EN00001694 Agency Number.

Application for Disability Income Insurance

Authorization to Obtain and Disclose Information

I permit the following entities to give all data or facts to The Union Central Life Insurance Company ("the Company"), its reinsurers, or any other agent or agency acting on the Company's behalf: (1) health care providers; (2) hospitals; (3) insurers; (4) the Medical Information Bureau, Inc. (MIB); (5) consumer reporting agency; (6) government agency; (7) financial institution; or (8) employer; about the proposed insured's or claimant's: (1) physical or mental condition; (2) medical care, advice, or treatment; (3) use of drugs, alcohol, or tobacco; (4) HIV, AIDS and sexually transmitted diseases; (5) prescription drug records; (6) financial status; (7) employment status; or other relevant data or facts about the proposed insured or claimant, including wages and earnings, or other insurance coverage.

Data or facts obtained will be released only: (1) to reinsurers; (2) to the MIB; (3) to persons performing business duties as delegated or contracted for by the Company related to the proposed insured's application or claim or other insurance-related functions; (4) as permitted or required by law; (5) to government authorities when necessary to prevent or prosecute fraud or other illegal acts; and (6) to any person or entity having an authorization expressly permitting the disclosure. The personal data or facts used or disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations.

The above data and facts will be used to: (1) underwrite an application for coverage; (2) obtain reinsurance; (3) resolve or contest any issues of incomplete, incorrect, or misrepresented information on the application identified above which may arise during the processing or review of the application, or any other application for insurance; (4) administer coverage and claims; and (5) complete a consumer report, investigative consumer report or telephone interview about the proposed insured or claimant.

I agree that this authorization is valid for two and one-half years from the date shown below. I also agree that a copy is as valid as the original. I, or my authorized representative, am entitled to a copy. For purposes of collecting data or facts relating to a claim for benefits, this authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revoking this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failing to sign, or revoking this authorization, may impair the Company's ability to process my application or evaluate my claim and may be a basis for denying this application or a claim for benefits.

I acknowledge receipt of the Notice of Insurance Information Practices.

Dated at: ____________________ ________ ________ ________ ________
City State Month Day Year

______________________________ X ______________________________
Print or Type Proposed Insured Name. Signature of Proposed Insured.

This Authorization complies with the HIPAA Privacy Rules.

Taxpayer Identification Number (TIN)

Social Security Number: ____________________

Under penalties of perjury, I certify that:

1) The social security number shown above is my correct TIN (or I am waiting for a number to be issued to me); and
2) I am not subject to backup withholding either because: (a) I am exempt from backup withholding; (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding.
3) I am a U. S. Person (including a U.S. resident alien).

Cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

X ______________________________ ____________
Signature of Proposed Insured (or Owner, if not Proposed Insured) Date

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Certificate of Delivery

This acknowledges that the undersigned has this date made application for a

Disability Income Insurance ______ policy to be issued by The Union Central Life Insurance Company, Cincinnati, Ohio, and that an Outline of Coverage of such policy was delivered to the undersigned at the time the application was made.

Date: ______

Signature of Applicant: ______